PRINTED: 09/06/2023 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
	34G352	B. WING			09/06/2023	
NAME OF PROVIDER OR SUPPLIER HILLTOP HOME			STREET ADDRESS, CITY, STATE, Z 2820 KIDD ROAD RALEIGH, NC 27610	IP CODE		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO  DEFICIENCE	TION SHOULD I THE APPROPR		
§460.84(d)(2), §482.6 §483.475(d)(2), §484 §485.542(d)(2), §485 §485.920(d)(2), §491  *[For ASCs at §416.5 at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD II (2) Testing. The [facil to test the emergency must do all of the following the following the following the following the following the following the facility of the facility of the facility of the facility of the emergency from engaging community-based or functional exercise for actual event.  (ii) Conduct an addition of the following the facility of the facility of the emergency from engaging community-based or functional exercise for actual event.  (ii) Conduct an addition of the following the facility of the	2)  113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), 1.102(d)(2), §485.68(d)(2), 1.625(d)(2), §494.62(d)(2).  14, CORFs at §485.68, REHs Organizations" under 1 §485.920, RHCs/FQHCs at Facilities at §494.62]:  Ity] must conduct exercises 1 y plan annually. The [facility] 1 owing:  I-scale exercise that is 1 ery 2 years; or 1 nity-based exercise is not 1 a facility-based functional 1 rs; or 1 experiences an actual 2 emergency that requires 3 regency plan, the [facility] is 3 in its next required 3 individual, facility-based 4 individual, facility-based 5 individual, facility-based 6 individual, facility-based	E 0	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		34G352	B. WING _		09	/06/2023
NAME OF I	PROVIDER OR SUPPLIER  HOME			STREET ADDRESS, CITY, STATE, ZIP 2820 KIDD ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 039	a facilitator and incla a narrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [facility analyze the analyze the analyze the the annually. The hosp (i) Participate in a facommunity based of (A) When a community accessible, conduct functional exercise (B) If the hospice of the analyze the emergency plarengaging in its next community-based of facility-based functionset of the emerge (ii) Conduct an addopposite the year the exercise under parais conducted, that in to the following:  (A) A second full-second full-s	udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed.  18.113(d):] Dices that provide care in the energency plan at least provide care in the energency plan at least provide emergency plan at least provide exercise that is every 2 years; or unity based exercise is not at an individual facility based every 2 years; or experiences a natural or experiences a natural or exercise or individual considerational exercise following the ency event.  Ititional exercise every 2 years, the full-scale or functional exercise or individual consideration of the full-scale or functional exercise or individual consideration of the full-scale or functional exercise that is or a facility based functional consideration of the full-scale or functional exercise that is or a facility based functional	E 03	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G352	B. WING_		09/	/06/2023
NAME OF F	PROVIDER OR SUPPLIER PHOME			STREET ADDRESS, CITY, STATE, ZIP C 2820 KIDD ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based functi (B) If the hospice eman-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disasted (C) A tabletop exertifacilitator that including and a set of problem messages, or prepare challenge an emerging (iii) Analyze the homaintain document	of problem statements, or prepared questions ge an emergency plan.  ices that provide inpatient hospice must conduct elemergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not an annual individual onal exercise; or experiences a natural or noty that requires activation of a trequired full-scale community sed functional exercise of the emergency event. Ititional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or cise or workshop led by a des a group discussion using a relevant emergency scenario, on statements, directed ared questions designed to gency plan.  spice's response to and ation of all drills, tabletop ergency events and revise the	E 03	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		34G352	B. WING _		08	0/06/2023
NAME OF I	PROVIDER OR SUPPLIER  HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2820 KIDD ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	§482.15(d), CAHs a (2) Testing. The [PF conduct exercises t twice per year. The do the following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based functi onset of the emerge (ii) Conduct an and that may include following: (A) A second full-second functional exercise; (B) A mock (C) A tabletop of led by a facilitator a discussion, using a emergency scenari statements, directe questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must of test the emergency plants [PRTF, Hospital, CAH] must annual full-scale exercise that d; or inity-based exercise is not an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event.  [additional] annual exercise or e, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is not includes a group narrated, clinically-relevant or, and a set of problem d messages, or prepared to challenge an emergency  [facility's] response to and ation of all drills, tabletop ergency events and revise the explan, as needed.	E 03	39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G352	B. WING			09/	06/2023
NAME OF I	PROVIDER OR SUPPLIER  HOME			2	TREET ADDRESS, CITY, STATE, ZIP CODE 820 KIDD ROAD RALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	(2) Testing. The PA exercises to test the annually. The PACI following: (i) Participate in an is community-base (A) When a community-based (A) When a community-based function (B) If the PACE expressible, conduction (B) If the PACE expressible, conduction (B) If the PACE expressible, conducted that end emergency planengaging in its next based or individual exercise following the exercise under participate (a) Conducted that exercise under participate (A) A second full-scommunity-based of functional exercises (B) A mock disasted (C) A tabletop exercise a facilitator and inclusing a narrated, of scenario, and a set directed messages designed to challer (iii) Analyze the PA maintain document exercises, and emergace's emergency *[For LTC Facilities*]	CE organization must conduct be emergency plan at least a corganization must do the annual full-scale exercise that districts an annual individual, and exercise; or periences an actual natural or ency that requires activation of an the PACE is exempt from a required full-scale community, facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based go rer drill; or recise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. ACE's response to and cation of all drills, tabletop ergency events and revise the or plan, as needed.	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G352	B. WING _		09.	/06/2023
				STREET ADDRESS, CITY, STATE, ZIP CODE 2820 KIDD ROAD RALEIGH, NC 27610		
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based function (B) If the [LTC facility-based function (B) If the [LTC facility is exemined a full-scale individual, facility-based individual, facility-based following the onset (ii) Conduct an additional exercise; (B) A mock disasted (C) A tabletop exert a facilitator includes narrated, clinically-rand a set of problem essages, or preparated, clinically-rand a set of problem essages, or preparated, clinically-rand maintain docume exercises, and emergically facility and including the including and maintain docume exercises, and emergically facility facility facility.	plan at least twice per year, and staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not an annual individual, onal exercise.  ty] facility experiences an an-made emergency that of the emergency plan, the of the emergency plan, the of the emergency event. In the exercise of the emergency event. In the exercise that not limited to the following: cale exercise that is or an individual, facility based or exercise or workshop that is led by a group discussion, using a relevant emergency scenario, an statements, directed ared questions designed to gency plan.  To facility] facility's response to mentation of all drills, tabletop ergency events, and revise the discussion, as needed.  183.475(d)]:  F/IID must conduct exercises and plan at least twice per year.	E 03	39		

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E 039	accessible, conduction facility-based functional exercise emergency event.  (ii) Conduct an add may include, but is (A) A second full-socommunity-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clusing a narrated, clusin	d; or unity-based exercise is not that an annual individual, onal exercise; or experiences an actual natural or ncy that requires activation of any, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or an individual, facility-based or ar drill; or cise or workshop that is led by undes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. [IIID's response to and action of all drills, tabletop ergency events, and revise the expense of any plan, as needed.  [IIII]  [II	E 039			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER HOME			28	FREET ADDRESS, CITY, STATE, ZIP CODE 320 KIDD ROAD ALEIGH, NC 27610		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	or man-made emer of the emergency pengaging in its next community-based of functional exercise emergency event.  (ii) Conduct an add opposite the year the exercise under parais conducted, that limited to the follow (A) A second functional exercise; (B) A mock disa (C) A tabletop of fun	experiences an actual natural regency that requires activation plan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the ditional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing:  Ill-scale exercise that is or an individual, facility-based for exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem do messages, or prepared of the challenge an emergency.  A's response to and maintain and revise the HHA's is needed.	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 2820 KIDD ROAD RALEIGH, NC 27610		
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E 039	questions designed plan. If the OPO eman-made emergency planengaging in its new following the onse (ii) Analyze the OF documentation of emergency events OPO's] emergency events OPO's] emergency events OPO's] emergency events of Conduct a paper least annually. A tadiscussion led by clinically-relevant of problem statem prepared question emergency plan. (ii) Analyze the RN maintain documer and emergency events of problem statem prepared question emergency plan. (iii) Analyze the RN maintain documer and emergency plan, a This STANDARD Based on documer facility failed to en mock disaster drill their Emergency F conducted. This p clients (#1, #2,#3) Review on 9/5/23 include a full-scale exercise.	xperiences an actual natural or ency that requires activation of an, the OPO is exempt from at required testing exercise to f the emergency event. PO's response to and maintain all tabletop exercises, and and revise the [RNHCI's and y plan, as needed.  3.748]:  RNHCI must conduct the emergency plan. The RNHCI ring:  er-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set ents, directed messages, or is designed to challenge an all tabletop exercises, vents, and revise the RNHCI's	EC	039		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2820 KIDD ROAD RALEIGH, NC 27610		
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E 039	hospital with an act	ent happened at the local ive shooter possibly in the r no documentation of the	E 039			
W 252	PROGRAM DOCU CFR(s): 483.440(e) Data relative to acc specified in client in	MENTATION	W 252			
	Based on observatinterviews, the facil relative to the according terms and the control of the co	s not met as evidenced by: iions, record reviews and ity failed to ensure data mplishment of objective ented in measurable terms. audit clients (#2, #9, #13 and are:				
	Program Plan (IPP) formal training program eutral or positive r while being assisted to be collected at leand 2nd shift, attenseconds as noted v and focused on the at least 4 times per 3 times per week of over hand assistance seconds with data to per week on 1st shift week on 2nd shift, g	3 of client #2's Individual dated 1/31/23 revealed trams for demonstrating a esponse for at least 5 seconds do to brush his teeth with data ast 5 days per week on 1st ding to a musical toy for 10 with his ability to remain alert toy with data to be collected week on 1st shift and at least in 2nd shift, tolerating hand be collected at least 4 days ft and at least 3 days per grasping a small object placed conds with data to be				

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		34G352	B. WING _		09	/06/2023
NAME OF I	PROVIDER OR SUPPLIER  HOME			STREET ADDRESS, CITY, STATE, ZIP 2820 KIDD ROAD RALEIGH, NC 27610	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 252	collected at least 5 and at least 3 times orienting to a sound or head turn with dadays per week on 1 week on 2nd shift.  Review on 9/6/23 or sheets for August 2 documentation on a documentation for 3 attending to a musi documentation in A days in September hand over hand ass 5 days of documentation and zero days of documentation and zero days of documentation in A days in September hand over hand ass 5 days of documentation in A days in September hand zero days of documentation in A days in September hand zero days of documentation in A days on 1st shift and zero 1st or 2nd shift in Sound had 15 days on 1st shift and zero 1st or 2nd shift.  B. Review on 9/5/23 delays on 1st shift and zero 1st or 2nd shift.  B. Review on 9/5/23 delays on 1st and 2revealed for reaching out with play with a days per week or eye contact with sp to him with data to on 1st and 2nd shift presented on either	times per week on 1st shift and disource as noted by eye gaze at to be collected at least 5 st shift and at least 4 days per demonstrating a positive or a 1st shift and zero days of September on 1st or 2nd shift, cal toy had 5 days of ugust on 1st shift and zero for 1st or 2nd shift, tolerating sistance to play with a toy had tation in August on 1st shift ocumentation in September for sping a small object placed in sof documentation in August or documentation in August or documentation in September of documenta	W 25	2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 252	Review on 9/6/23 of sheets for August 2 documentation on assistance on 1st should documentation on 2 documentation on 3 of 2nd shift, 14 day maintaining eye conducted and 11 days of documentation of 3 documentation of 4 documentation on 1 documentation on 1 documentation on 2 documentation of 4 documentation of 4 documentation of 5 do	of client #9's program plan data 2023 revealed 3 days of reaching out with physical shift and 12 days of 2nd shift, 15 days of 2nd shift, 15 days of reacting positively to positive and 11 days of documentation as of documentation for 11 ntact with speaker on 1st shift 12 umentation on 2nd shift and 3 13 tion on 1st shift for looking 10 days of documentation on 13 of client #13's IPP dated 10 days of documentation on 13 of client #13's IPP dated 15 umal training programs 15 ist with putting on her shirt. 15 yes per week 1st shift. Objective 15 umek on 1st and 2nd shift. 15 gate her IPad to choose what 15 atch, collect data three days 15 collect data five days per week 15 umentation 15 collect data two 15 th assistance collect data two 15 days of 15 day	W 25				

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NAME OF PROVIDER OR SUPPLIER  HILLTOP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE  2820 KIDD ROAD  RALEIGH, NC 27610				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
W 252	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 2	52				